DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/12/2007 FORM APPROVED

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION		(.43) DATE SURVEY COMPLETED	
	, 	09G171	B. WING			C	
NAME OF F	PROVIDER OR SUF	LIER	s	TREET ADDRESS, CITY, STATE, ZIP C 1701 24TH STREET, NE WASHINGTON, DC 20002		29/2007	
(X4) ID PREFIX TAG	(EACH DEF	RY STATEMENT OF DEFICIENCIES SENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THIS DEFICIENCY)	N SHOUL) BE EAPPROFRIATE	(X5) COMPLETION DATE	
W 000	INITIAL CON	VIENTS	W 00	D		-	
W 114	26, 2007 thro survey was in A random sar from a popula degrees of distributions and staff, and incident repor revealed that with the Cond Treatment. 483.410(c)(4) Any individual record must not the clients and the clients.	risit was conducted from November 19h November 29, 2007. The tiated using the full survey process. 19le of two clients were selected ian of four females with various abilities. If the survey were based on 11the home, interviews with clients the review of records, including 15s. The outcome of the survey 16st facility failed to be in compliance 16st of Participation in Active 16s	W 114		assessment is	1/3/68	
	The finding in	ludes:					
W 124	2007 at 4:10 F that Client #1 Review of the dated July 1, 2 was not signer assessment.	ance conference on November 26, M, the direct care staff indicated as one to one support services. slient's psychology assessment DC7 revealed that the assessment by the person completing the PROTECTION OF CLIENTS	W 124			·	
ORATORY	DIRECTOR'S OR F	RCVIDER/SUPPLIER REPRESENTATIVE'S SIGN.	ATURË	TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above an: disclosable 90 days following the date of survey whe her or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these do runnents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

DEPARTMENT OF HE ALTH AND HUMAN SERVICES PRINTED: 12/12/2007 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION ().3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G171 11/29/2007 NAME OF PROVIDER OR SUP ILLER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE CARECO 11 WASHINGTON, DC 20002 (X4) ID SUMMA LY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTIC N PREFIX (EACH DEFI :IENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROFINATE PREFIX REGULATOR (CIR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) W 124 Continued From page 1 W 124 The facility m st ensure the rights of all clients. Therefore the facility must inform each client, parent (if the lient is a minor), or legal guardian, of the client's nedical condition, developmental and behavior il status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on obs arration, staff interview, and record review, the far lifty failed to establish a system that would ensure alients that were informed of their risks and ben- fits of their medication for two of the two clients in the sample. (Client #1 and Client #2) The findings it clude: Client #1 \ as observed during the morning 1. The QMRP will ensure that the client's neother medication pais on November 26, 2007 at 6:05

PM and was a iministered Buspar 15 mg, Seroquel 100 ng and Depakote 500 mg. Interview with the Licensed Practical Nurse (LPN) on November 16, 2007 at approximately 6;40 PM revealed that client was prescribed these medications for behavioral management. Review of Client #1's current physician's orders revealed that the client was prescribed the aforementioned medications, tidde a day. Further interview with

medications, trace a day. Further interview with the LPN revealed that the medications were incorporated into the client. Behavior Support Plan (BSP) daied February 2, 2007 to address targeted behariors that included property destruction, directing, physical aggression, inappropriate touching self-injurious behaviors.

Interview with he Qualified Mental Retardation

provides written informed consent, per the District's Health Care Decisions Act for the rapies in place to assist the client to manage her behaviors.

7/3/4

and enuresis.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/12/2007 CENTERS FOR MEDI PARE & MEDICAID SERVICES FORM APPROVED OMB NO, 0938-0391 STATEMENT OF DEFICIENCIE: (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION () 3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING С 09G171 11/29/2007 NAME OF PROVIDER OR SUP LIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE CARECO 11 WASHINGTON, DC 20002 (X4) ID SUMMA IY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFI : IENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOUL) BE TAG REGULATOR YOR LSC IDENTIFYING INFORMATION) COMPLÉTION CROSS-REFERENCED TO THE APPROFRIATE TAG DATE DEFICIENCY) W 124 Continued Fr. m page 2 W 124 Professional (QMRP) on November 27, 2007 at approximately 9:30 AM revealed that Client #1's mother is ven involved in his life but are not the client's legal cuardians. Review of the client's, psychological assessment on November 27, 2007 at approximately 1:21 PM revealed that the client does not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, fir ances, treatment and medical matters. Then was no documented evidence that the facility obt lined consent from Client #2's mother of the realth benefits and risks of treatment assiciated with the use of his psychotropic riedications and corresponding BSP. Additior ally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. Client #2 was observed during the evening. 1 /3/ö8 medication pais on November 26, 2007 at 2. See response to #1 above. approximately 3::25 PM and was administered Paxil 30 mg, Z /prexa 10 mg, and Trazodone 50 mg. Review of the client #2's current physician's orders revealed that the client was prescribed the aforementions 1 medication and Zyprexa twice a day. Interview with the LPN on November 26, 2007 at approximately 6:40 PM revealed that Client #2 was rescribed these medications for behavioral management. Further interview with the LPN revea ed that the medications were incorporated ir to Client #2's BSP dated March 30, 2007 to addres a targeted behaviors that included disrobing and nasturbation, screaming/crying, physical aggre is on, property destruction, and self-injurious t shaviors.

Interview with ne QMRP on November 26, 2007 at approximately 9:30 AM revealed that Client

AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIER (X2) MUST LIER NAME OF PROVIDER OR SUP LIER CARECO 11 (X4) ID SUMMA: Y STATEMENT OF DEFICIENCIES (EACH DEFI (ENCY MUST BE PRECEDED BY FULL REGULATOF CR. LSC (DENTIFYING INFORMATION)) W 124 Continued Fit m page 3 #2's mother a id sister are involved in his life but are not the client #2's, ps 'chological assessment on November 27 2007 at approximately 1.21 PM revealed that he client does not have the ability to make decis one on his behalf regarding habilitation pic nring, residential placement, finances, trea ment and medical matters. There was no docur ented evidence that the tracility informed Clie t 11'2's mother or sister of the health benefits and r sks of treatment associated with the use of his saychotropic medications and corresponding BSP. Additionally, the facility failed to provide evir ence that substituted consent had been obtained from a legally recognized individual or entity. 3. The facility ailed to obtain consent prior to the use of sedatic 1 for a medical appointments and/or to notif the clients guardian the risks and benefits of tre trments for two of the two clients in	3 I A I EIVIEI	NT OF DEFICIENCIE:	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) M	ULTIPLE CONSTRUCT	OMB N	M APPRO <u>0. 0938-0</u>
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TAG REGULATOF CR LSC IDENTIFYING INFORMATION) REGULATOF CR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATOF CR LSC IDENTIFYING INFORMATION) W 124 #215 mother a id sister are involved in his life but are not the client dos sister are involved in his life but are not the client dos not have the ability to make decis ons on his behalf regarding habilitation pic nriing, residential placement, finances, trea ment and medical matters. There was no docun ented evidence that the facility informed Clie it #2's mother or sister of the health benefits and r sks of treatment associated with the use of his asychotropic medications and corresponding BSP. Additionally, the facility failed to provide evir ence that substituted consent had been obtained from a legally recognized individual or entity. 3. The facility ailed to obtain consent prior to the use of sedatic 1 for a medical appointments and/or to notif the clients guardian the rights and/or to notif the clients guardian the rights and the rights and the rights guardian the rights and the rights and the rights guardian the rights and the rights guardian the rights and the rights guardian t		SUMMA Y ST	ATEMENT OF DEFICIENCIES	T 10			
#2's mother and sister are involved in his life but are not the climates and sister are involved in his life but are not the climates legal guardians. Review of the client #2's, ps chological assessment on November 27 2007 at approximately 1.21 PM revealed that the client does not have the ability to make decisions on his behalf regarding habilitation pia nning, residential placement, finances, trea ment and medical matters. There was no documented evidence that the facility informed Client #2's mother or sister of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. 3. The facility ailed to obtain consent prior to the use of sedatic 1 for a medical appointments and/or to notif the clients muardian the risks and/or to notif the clients muardian the risks and	TAG	REGULATOF CIR I	Y MUST BE DOCOTORS S	PREFD	CROSS-REFERENCED TO THE APPR	ILIN DE	
#2's mother and sister are involved in his life but are not the climit's legal guardians. Review of the client #2's, ps chological assessment on November 27 2007 at approximately 1:21 PM revealed that he client does not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, trea ment and medical matters. There was no documented evidence that the facility informed Client #2's mother or sister of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. 3. The facility ailed to obtain consent prior to the use of sedation for a medical appointments and/or to notif the clients quardian the risks and/or the clients and clients an	W 124		age 3	10/ 1/			<u> </u>
share to not the clients quardian the risks and	ſ	#2's mother and sister are not the client." Solient #2's, psichol November 27, 200 revealed that he client make decisions of habilitation planning finances, trea ment was no documented informed Client #2's benefits and risks of the use of his psychogresponding BSP to provide evir ence been obtained from or entity. 3. The facility ailed use of sedation for a	ster are involved in his life but legal guardians. Review of the ogical assessment on 7 at approximately 1:21 PM ient does not have the ability on his behalf regarding g, residential placement, and medical matters. There is evidence that the facility is mother or sister of the health of treatment associated with motropic medications and a Additionally, the facility failed that substituted consent had a legally recognized individual to obtain consent prior to the a medical appointments.				Jaks.
	V 130 2	riat the client lias far 483.420(a)(7) PROT RIGHTS The facility must ensi	ure the rights of all clients.	W 130	The QMRP will ensure that all staff are tra on privacy issues, and that they support cli exercise their rights to privacy and persona		

DEPARTMENT OF HE ALTH AND HUMAN SERVICES I'RINTED: 12/12/2007 CENTERS FOR MEDI LARE & MEDICAID SERVICES FORM APPROVED <u>()MB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (E.C) DATE SURVEY IDENTIFICATION NUMBER. COMPLETED A. BUILDING С B. WING 09G171 11/29/2007 NAME OF PROVIDER OR SUP LIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE CARECO 11 WASHINGTON, DC 20002 (X4) ID SUMMA LY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFI : IENCY MUST BE PRECEDED BY FULL (X6) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD) BE REGULATOR (CIR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROFRIATE DATE DEFICIENCY W 130 Continued Fr m page 4 W 130 This STAND/ RD is not met as evidenced by: Based on observation, the facility failed to ensure that clients were provided privacy or taught to exercise prive by throughout the day for one of the four clients in he sample. (Clients #2 and #4) The findings include: During observations conducted throughout the survey on Nor ember 26, 2007, Client #2 was observed not using privacy, not encouraged or taught to exer lise her right to privacy. The staff failed to provi e privacy to clients and their personal issues. On November 26, 2007, the following opportunities to leach privacy to clients was not initiated by the staff at the facility. a. At 6:30 PN Cilient #2 was sitting in the living room and removed her top. The direct care staff and medicatic I were discussing her afternoon snack before receiving her medication. b. At 6:35 PM the medication nurse was observed adm nistering Client #2 her in the presence of or ner clients and staff in the living room. c. At 6:45 PM Client #2 stripped her pants below the waist, while sitting in the living room, no staff

FORM CMS-2567(02-99) Previous V raiona Obsolete

intervention of served

d. At 6:52 PM direct care staff was observed placing Client '2 on the toilet. The client sat on the toilet with the bathroom door wide opened. The direct are staff was observed going to the clients bedroom to retrieve some clothes. The direct care staff vas not encouraged to close the

Event ID: UKU111

Facility ID: 09G171

If continuation sheet Page 5 of 35

DEPARTMENT OF HE ALTH AND HUMAN SERVICES
CENTERS FOR MEDICARD SERVICES

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AND PLAN	IT OF DEFICIENCIES OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PIPLE CONSTRUCTION		(2 3) DATE SURVEY COMPLETED	
			09G171	B. WI	NG_		441	C 29/2007	
NAME OF	PROVIDER OR SUPI	LIER			67	DEET ADDRESS CON COLUMN		29/2007	
CAREC	O 11				١ ٠	REET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE			
(X4) ID	AMMI IZ		TEMENT OF DEFICIENCIES		,	WASHINGTON, DC 20002			
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W 130	Continued Fro	т раз	je 5	$\int \mathbf{w}$	เรก				
			n she was in the bathroom.	''					
W 137	e. At 7:50 PN giving Client # wide opened.	eired La be	et care staff was observed ed bath with the bedroom door	W	37				
	The facility mu Therefore, the have the right	facilit o reta	sure the rights of all clients. y must ensure that clients ain and use appropriate as and clothing.			The Residential Director (RD) will train ensure that people are able to use their of personal possessions, and that staff cheer sure that they provide people with their things.	wr k to make	1/5/08	
	Based on obsi review, the fac	rvatic lit∤ fa ie sor	not met as evidenced by: in, staff interview and record iled to ensure that clients hal clothing for one of the four (Client #3)			·			
	The finding inc	udes							
W 140	AM, Client #3 that had the in environmental at 10:30 AM, c drawers there on them. 483.420(b)(1)(The facility mu that assures a	vas olidals on naperoserva hree) CLIE at esta full and	2007 at approximately 9:40 observed with a pair of socks of Client #2. During the ction on November 30, 2007 ation of Client #3's dresser pairs of socks with her initials ENT FINANCES ablish and maintain a system of complete accounting of its entrusted to the facility on	W 1.	40	The Director of Disability Services will that the QMRP has copies of people's bestatements in their home.	en surè and :	1/3/08	
	This STANDA Based on staff	:D is intervi	not met as evidenced by: ew and record review, the						

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/12/2007 FORM APPROVED CENTERS FOR MEDI DARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION C(3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING_ 09G171 11/29/2007 NAME OF PROVIDER OR SUP "LIER STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 11 1701 24TH STREET, NE WASHINGTON, DC 20002 SUMMA LY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFI HENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROFRIATE PREFIX REGULATOF / (IR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) W 140 Continued Fr. m page 6 W 140 facility failed to maintain a system that assures a full and comp ete accounting of clients' personal funds entrusted to the facility on behalf of two of the two client: in the sample. (Clients #1 and #2) The finding in :ludes: In an attempt o review the financial records for Clients #1 and #2 on November 27, 2007 revealed that here were no bank statements available for review at the group home. Interview with the Quali led Mental Retardation Professional (QMRP) on November 27, 2007 indicated that he bank statements were located in the main of co and would be brought to the facility for review. By the end of the survey, the bank stateme it were not made available for review: It should be noted that the QMRP indicated that he clients received their monthly Social Securit Income (SSI). W 159 483.430(a) QUALIFIED MENTAL W 159 RETARDATIC N PROFESSIONAL Each client's active treatment program must be integrated, co-relinated and monitored by a qualified mental retardation professional. This STANDA (C) is not met as evidenced by: Based on obs invation, interview and record review the factity failed to ensure that each client's active reatment program was coordinated, ir tegrated and monitored by the Qualified Men al Retardation Professional (QMRP).

The findings ir clude:

The facility': QMRP failed to have client's legal

1. The QMRP will invite the person's guardian or family member via letter to participate in the

annual Individual Support Plan meeting

DEPARTMENT OF HE ALTH AND HUMAN SERVICES
CENTERS FOR MEDI CARE & MEDICAID SERVICES

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STATEMENT AND PLAN C			0	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		() (3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER	OR SUP	*LIER	036171	 _	DEET ADDRESS OFTE PEATE 710 CODE	11/2	9/2007
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W 159	Continu	ed Fr.	——— т раде	9 7	W 159			<u> </u>
		Indivic		ember participated in her oport Plan (ISP) meeting.		- <u> </u>		
	clients	who wa	s recei	P failed to ensure that iving psychotropic sychiatric assessment. [See		2. The QMRP will schedule a psychiatrassessment for each person who is receive psychotropic medications.	— — — — ic vir g	1/3/08
	objective medica the inte	es wa tion tra rdiscip hensiv	develo ning pr nary to asses	P failed to ensure that an opped to address self rogram need as identified by eam (IDT) in the ssment. [See W227]		3. The RN Supervisor will schedule an assessment to determine whether people candidates for self-medication. The QM review the results of assessments when the complete and develop programming if appropriate.	[R] 'will	1/3/08
	5. The client's	ous ac facility Individ	ive trea is QMR Lia Proj	P failed to provide atment. [See W249] P failed to ensure that each gram Plan (IPP) objectives sistently and accurately.		4. The QMRP will review each person's objectives as identified in the IPP and reappropriately. 5. The QMRP will retrain all staff to easy program activities are accurately and core.	vis: them sure that	1/3/08 1/3/88 1/3/08
	[See W 4. The identifier achieve	(252] facility od in the	: QMR ∈ client	P failed to revise objectives s's IPP that had not been 7]		4. The QMRP will review all IPPs and not them appropriately.		1/3/08
W 195	The fac	ility mu	ist ensu	EATMENT SERVICES ure that specific active quirements are met.	W 195	The Director of Disability Services made change in personnel to address Active T and any other concerns in the concerns it home. The new QMRP started on Nove 2007, and is assigned full time to the hor Additionally, a new Residential Director well experienced in active treatment and	reament in the ent or 28, me r, who is I human	
	Based of review, active to the facility	on obs the fac reatme lity fails	crvation t lity fail at servi at to en	not met as evidenced by: n, interview and record ed to ensure continuous ices (See W196 and W249); nsure that clients were aught to exercise privacy		rights, and can provide supports to people home in accordance with their ISPs and regulatory requirements, was hired and be work on December 27, 2007. The home staffed with a new RN Supervisor who s November 2007. The new team will prove the retraining to all facility staff on providing	leithe begin sis uso _ staned in ovide	

DEPARTMENT OF HI ALTH AND HUMAN SERVICES

CENTERS FOR MED CARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIE
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

C

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AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	((3) DATE SURVEY COMPLETED		
		09G171	B. WING		11/2	C 29/2007	
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W 196	(See W130); legal guardial her annual In (See W209); clients who w medications here with the interdisciple comprehensing facility failed the interdisciple facility failed the program Plan consistently a Qualified Mer (QMRP) failed revised after the with the idention of the failure of the fa	he facility failed to have client's or family member participated in lividual Support Plan (ISP) meeting he facility failed to ensure that its receiving psychotropic act a psychiatric assessment (See cility failed to ensure that an active loped to address self in ng program need as identified by inary team (IDT) in the reassessment (See W227); the reasure that each client's Individual (IIPP) objectives are documented at accurately (See W252); and the all Retardation Professional consure each client's IPP was the client failed to make progress in ied objectives (See W257). If these systemic practices results in the facility to adequately provide and services. ACTIVE TREATMENT If it receive a continuous active of ram, which includes aggressive, in lementation of a program of a generic training, treatment, health it slatted services described in this is directed toward: It is in the behaviors necessary for a cition with as much self and independence as possible;	W 195	exercising privacy and all aspects of a person's ISP. The QMRP will ensure who are receiving psychotropic media received a psychiatric assessment. The ensure that the clients are properly asseligibility for self-medication, that far members are properly notified in written meetings and requested to attend; and IPPs are reviewed for client progress appropriately according to the person' or lack of progress. The QMRP and Fensure that all staff are trained on each IPPs and BSP, and that staff documen accordance with the protocols governing	e that people cations also hey will sessed for mily ing of team that all and revised 's progress CD will he per on's to both in	1/3/08	
	or loss of curre	e ition or deceleration of regression in the optimal functional status.					
	THIS STANDA		[

DEPARTMENT OF HE ALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

FRINTED: 12/12/2007 FORM APPROVED CMB NO. 0938-0391

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STATEMEN AND PLAN (T OF DEFICIENCIES OF CORRECTION	(X1)) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X 3) DATE SURVEY COMPLETED	
	ı		09G171	B. WI	1G_	<u> </u>	11/:	C 29/2007
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W 196	Based on obs record review clients receive program in ac made by the inthe two clients #1 and #2) The findings in I. The facility received contininher Individu A. On Novem observed from following: 1. At 4:00 PM her bedroom of the bedroom on the living room an hungry. The sitting in a character pant and the sitting room and her head again present, and the sitting room and her head again present, and the direct carrier pants up, the client complete the sitting in the client complete the sitting in the client complete the client complete the sitting in the client complete the client client client complete the client client client complete the client cli	clude: ailed to e unous ac ul Habilita ber 26, 2 4:00 PM the clier as overh e client, if lindicate aff also s r listenin the surv bserved st the wa ever was if the clier staff rec iree time lied.	staff interviews, and ity failed to ensure that yous active treatment with recommendations blinary team (IDT) for two of in the sample. (Clients ensure that Client #2 tive treatment as outlined ation Plan (IHP). 007 Client #2's was I to 8:40 PM revealed the interview of the staff returned alone in heard screaming. After the staff returned to the ed that the client was stated that the client was	W	ļ	I. The QMRP will review the 24-hour a treatment schedule and revise it as new QMRP will review the IPPs for the per ensure that they are appropriate, and in programming for personal care and hyg QMRP will train staff on implementation active treatment schedule, the BSP, and ensure that staff document programs are and timely per the established protocole QMRP will ensure that the staff are approximed to assist the person to exercise his privacy, and assist her to maintain her of The QMRP will ensure that staff engage client according to her schedule, and releaving her unattended and alone in her other than at sleep time. The QMRP an ensure that the person receives appropriate places, in accordance with dietary plan. See response to W 195.	led. The son ind clud; ricin. The on o the lift s and curately s. The propilately let right to lightly. It the frain from room, d RI) will attentions.	1/3/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDI JARE & MEDICALD SERVICES

PRINTED: 12/12/2007 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(C(3) DATE S COMPLI	
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	LIER	170	1 24TH STREET, NE	CODE	
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bedroom alor the bedroom water. The difference of the client held on the entire fee finished the cand slightly life. At 5:08 PM wall, four time. The client was and removed undergarmer. At 5:20 PM and removed undergarmer. At 5:20 PM and removed undergarmer. At 5:20 PM attempting to client was section consumed the client consumed the consumer to consume the consumer to consumer the consumer the consumer to consumer the consumer the c	e. The the direct care staff entered with a bag of potato chips and ect care staff was observed ant potato chips and water. The the direct care staff's leg during ing. After the potato chips were ent grabbed both of the staff's legs ing him from the floor. If the client banged her head on the staff's legs ing him from the floor. If the client banged her pants down her soiled adult protective ins (APU). If the client came into the living in a chair. If the medication nurse was see the client her dinner while the set in the living room chair. The inside two spoonfuls of food. The first two spoonfuls of food. The first crushed into her food. The client refused the dication. Several minutes later the parved putting the remained into a jelly sandwich. The client medication sandwich. If the client removed her top is ports bra.	W 196	DEFICIENCY		
			•	,	
	ROVIDER OR SUP 11 SUMMA (EACH DEFINE REGULATOR REGULATOR Continued From alor the bedroom alor the bedroom water. The definished the continuence of the entire fee finished the entire fee finished the continuence of the entire fee finished the continuence of the entire fee finished the continuence of the entire fee finished the entire fee finished the continuence of the entire fee finished the entire fee finished the continuence of the entire fee finished the entire fee finished the continuence of the entire fee finished the entire fe	PEORRECTION IDENTIFICATION NUMBER: 09G171 ROVIDER:OR SUP 'LIER 111 SUMMA :Y STATEMENT OF DEFICIENCIES (EACH DEFI JIENCY MUST BE PRECEDED BY FULL REGULATOF / (IR LSC IDENTIFYING INFORMATION)	ROVIDER OR SUP LIER SUMMA LY STATEMENT OF DEFICIENCIES (EACH DEFI JENCY MUST BE PRECEDED BY FULL REGULATOF / OR LSC IDENTIFYING INFORMATION) Continued Fir im page 10 bedroom alor 2. The the direct care staff entered the bedroom with a bag of potato chips and water. The direct care staff seg during the entire fee ing. After the potato chips were finished the c. ent grabbed both of the staff's legs and slightly lif ing him from the floor. 6. At 5/08 PN, the client banged her head on the wall, four time s. 7. At 5/12 PN, the client pulled her pants down and removed her soiled adult protective undergarmen's (APU). 8. At 5/20 PN the client came into the living room and sat in a chair. 9. At 6/20 PN the medication nurse was attempting to be the client her dinner while the client was see act in the living room chair. The client consum id two spoonfuls of food. The nurse mixed 1/4 teaspoon of the client refused the food and medications in to her food. The client refused the food and medications is one putting the remained medications in a jelly sandwich. The client consumed the medication sandwich. 10. At 6/30 Pl 1, the client removed her top, exposing her a ports bra. 11. At 6/45 Pl 1, the client pulled her pants down below the wait!. 12. At 6/52 Pl 1, the direct care staff took the client to the be throom. The client sat on the toilet	ROVIDER OR SUP LIEF 111 SUMMA LY STATEMENT OF DEFICIENCIES (EACH DEFI IRENCY MUST BE PRECEDED BY PILL REGION OF CRESCIENTIFYING INFORMATION) Continued Fir im page 10 bedroom after 2. The the direct care staff entered the bedroom with a bag of potato chips and water. The direct care staff was observed feeding the clamb color chips and water. The client held on 3 the direct care staff seg during the entire fee ing. After the potato chips were finished the cent graphs down and removed are soiled adult protective undergarmen's (APU). 8. At 5:20 PN the client builed her pants down and removed ier soiled adult protective undergarmen's (APU). 9. At 6:20 PV the medication nurse was attempting to at the olient her dinner while the client was sea ext in the living room chair. The client consum of two spoonfuls of food. The nurse mixed 1 4 teaspoon of the clients crushed medications ir to her food. The client refused the food and medication. Several minutes later the nurse was observed intensity the remained medications ir to a jelly sandwich. The client consumed the medication sandwich. 10. At 6:30 PI I, the client pulled her pants down below the walk! 11. At 6:45 PI I, the client pulled her pants down below the walk! 12. At 6:52 PI I, the direct care staff took the client to the be throom. The client sat on the toilet.	ROWIDER OR SUP LIER 111 STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE (ACAC HORE) STATEMENT OF DEFICIENCIES (CACH ORE) STATEMENT OF DEFICIENCY CONTINUED FOR MAJOR STATEMENT OF DEFICIENCY CONTINUED FOR MAJOR STATEMENT OF DEFICIENCY CONTINUED FOR MAJOR STATEMENT OF DEFICIENCY PREFIX (CACH ORE) SEARCH STATEMENT OF THE ACT OF THE APPROPRIATE PREFIX TAGS PROVIDERS PLAN TO CONDUCT ON THE APPROPRIATE CACH STATEMENT OF THE ACT OF THE ACT OF THE APPROPRIATE PREFIX (CACH ORE) SEARCH SCHOOL SEARCH SEA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDI ARE & MEDICAID SERVICES

PRINTED: 12/12/2007 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIE: OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	C.3) DATE SURVEY COMPLETED			
		09G171	B, WING			29/2007		
NAME OF P	ROVIDER OR SUP	LIIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE WASHINGTON, DC 20002					
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W 196	13. At 7:15 P her bedroom hygiene. B. Interview v 27, 2007 reve on staff for ba On November wearing an addependent on morning of No observed assistaff confirme with bathing, or Review of the	m page 11 A, the client was escorted back to complete evening personal ith direct care staff on November also that Client #2 was dependent also personal needs 26, 2007, the client was observed all protective under garments and staff for toileting. Also on the rember 27, 2007, the staff was atting the client with her jacket. The that the client needs assistance ressing and toileting. client's habilitation record on 2007 revealed no documented	W 196					
	evidence of tr Further review failed to revea skills had bee C. Review of objectives to a communication living skills, did the direct participate in objectives as 1. Given vert perform an active results of the with 70% accommunication 2. Given vert	in ng programs in these domains. It of the client's habilitation records at that the client's personal care itientified/assessed. The Client #2's IPP revealed a thance money management, and identify activities of daily at no time during the observations care staff encourage the client to any of the aforementioned program i lentified below: It assistance, [the client] will on with an object upon request a acy per sessions for three						

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/12/2007 CENTERS FOR MED CARE & MEDICAID SERVICES FORM APPROVED <u> DMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIE; (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION ((3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 09G171 11/29/2007 NAME OF PROVIDER OR SUF ILLER STREET ADDRESS, CITY, STATE, ZIP CODE CAREÇO 11 1701 24TH STREET, NE WASHINGTON, DC 20002 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEF DIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATOR Y OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROLIRIATE DEFICIENCY) W 196 Continued From page 12 W 196 (by touch) wit 170% accuracy for three consecutive rionths. 3. Given vert al prompts, [the client] will rinse her toothbrush or 50% of the trials recorded per month for thrue consecutive months by 10/07. Given vert al prompts and hand over hand assistance, [t e client] will identify coins with 75% accuracy per lession as measure by the record trials per mon h for six consecutive months. Interview with the QMRP and review of the IPP data book revealed no documentation on any of the program cojective since June 2007. There was no evider certhat these program objective had been imp ernented since June 2007. D. Interview vith the direct care staff indicated that the client preferred to stay in her bedroom. Review of Client #2's Behavior Support Plan (BSP) dated It arch 30, 2007 indicated proactive strategies to it clude: 1. The client rhould be engaged in a task as often as possible to alleviate boredom. 2. The client should be closely supervised to prevent disrot ng. The client should wear an additional one or two layers of c othing to prevent or delay clothes stripping. In the event that clothes stripping occurs, direct are staff should cover the client

or bathroom to redress.

throughout the day, every day.

with a towel pr or to escorting her to the bedroom

Staffishould provide frequent verbal praise

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPAR	TME	NT OF HE	ALT:	AND HUMAN SERVICES				PRINTE	D: 12/12/2007 MAPPROVED
STATEMEN	<u> 70.</u>	DEFICIENCIE:	<u> FRE</u>	& MEDICAID SERVICES				OMBIN	O. 0938-0391
AND PLAN	OF CO	DEFICIENCIE: DRRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		LTIPLE CONSTRUCTION DING	(2'3) DATE	
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CAREC	11	<u> </u>	,			ľ	TREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE WASHINGTON, DC 20002		
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W 196	Со	ntinued Fro	m pa	ge 13	W	19	6		
	īmţ	plemented	he: BS	nce that the direct care staff SP as written.					
	on AM	November revealed t	29, 20 ie foll				,		
	- ! - !	7 AM Heli 7:30 AM r 8 AM sign 8:30 AM c	irı se ledica break eanin	fast; og the table hold dish cloth					
	bru	wipe tabl∈ sh teeth (ri 9 AM- 4 P 5 PM com	with : ise to // Day nunic	staff assistance. Afterward othbrush):					
	-	7 PM Mor	ousel ∌y Ma ath/sh	nold chores; nagement; nower (OT objective);					
	-	8 PM Sna 8:30 Bedti	k; and ne⊩	mplement Client #2's activity					
	sche	edule as w	itten.						
	ISP.	eved active	treatr	to ensure that Client #1 nent in accordance with her			II. See response to I above. The QMRP ensure that staff are fully trained to comp implement and document the person's BS	-4	1/3/68
'	4:00 	PM throu	h 8.40	November 26, 2007 from DPM revealed the following:					
1	1. A #1 w PM:	t 3:55 PM /as observ	Upor d slee	n entry into the facility, Client eping in her bed until 5:45					
									1

DEPARTMENT OF HLA.TH AND HUMAN SERVICES
CENTERS FOR MEDI 24/RE & MEDICAID SERVICES

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	OF DEFICIENCIE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION		(.(3) DATE SURVEY COMPLETED	
	!		A. BUILDING			-	
		09G171	.B. WING			C 9/2007	
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W 196	administered I medication ro) 3. At 6:30 PN 4. At 6:47 PN staff's cellular rooms a point of the property of the property of the program in consecutive multiple and program	the medication nurse the client's medication in the thi; the client had dinner; the client threw a direct care belone on the floor; the client was observed on d at the kitchen table for 20 the client was observed sleeping dining room table for nearly one the client 's 1:1 support staff assisting Client #3 in her activities kills; and the client's 1:1 support staff was rting the client to her bedroom to ning personal hygiene. th the direct care staff on 2007 at approximately 1:00 PM the Client #1 required 1:1 staff ent behavior incidents and to lementation of the following 1, [the client] will get her things for dependently 100% for three	W 196	DEPICIENCY			
	the month for t	ree consecutive months;					

DEPAR	RTMĖNT OF HE	ALTH.	AND HUMAN SERVICES				PRINTE	D: 12/12/2007
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AND PLAN	IT OF DEFICIENCIE OF CORRECTION	. (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION IG	(C3) DATE	
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W 196	Continued Fro	m page	e 15	W:	196			
	3. Given a pa will pick out the of the item shathree consect	tteirh of e value win 60° tive mo	coins and bills, [the client] of money to match the price % of the trials per month for nths;	VV	190			
·	consecutive п	with 10 Onths;	pts, [the client] will prepare 0% independence for three					
	[the client] will	stay on 100% c	vith arts and crafts of choice, task for up to 30 minutes of the tails within a month for onths; and					
	6. [The client exercises for months.	wlll par 0 minut	ticipate in physical fitness les for 12 consecutive					
	implemented to objective since the QMRP cou	s no ev le afore at leas firmed (PP dated September 13, idence that the facility ementioned program to June 2007. Interview with that the program objective since at least June 2007.					
	C. The 1:1 sudocument Clie (BSP) as writte	It #1's F	aff failed to implement and Behavior Support Plan					
	observed throw	ing a di	7 at 6:47 PM, Client #1 was rect care staffs cellular le sitting idle after her			·	•	
	penavior of prop The proactive engagement in	oerty de trategie a task a	ed 2/7/07 revealed a target estruction (throwing items). s of the BSP include: as often as possible to vide 1:1 support staffing;			. •		

DEPARTMENT OF HE ALTH AND HUMAN SERVICES CENTERS FOR MEDI ARE & MEDICAID SERVICES

PRINTED:	12/12/2007
FORM	APPROVED

STATEMEN	NT OF DEFICIENCIE		(X4) DBC)//DEC/00-10-10-10-10-10-10-10-10-10-10-10-10-1				CIMB N	<u>0.</u> 0938-039
AND PLAN	OF CORRECTION	ľ	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIFLE CONSTRUCTION	() 3) DATE	
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NAME OF	PROVIDER OR SUP.	LIER					<u> </u>	29/2007
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W 196	Continued Free	n pag	je 16	W.	106			
,		nt, ca	sual verbal praise, and pats		190			
W 209	destruction as	ıent ti requir	curred the 1:1 support staff ne episode of property ed by the BSP, IDUAL PROGRAM PLAN	W 2	209			
	Participation by client is a min required unless or inappropria	the critical the position of t	client, his or her parent (if the the client's legal guardian is participation is unobtainable					
	determined that member partic ; Support Plan : s clients in the s a	d revi t clien pated SP) m mple.	not met as evidenced by: ew, it could not be t's legal guardian or family in her annual Individual secting for two of the two (Clients #1 and #2)					
	The findings ir c	lude:				•		
	1. During the 126, 2007 at 4: 0 mother is very in care. Review of meeting was hereview of the 131 revealed seve a interdisciplinar.	ntrand PM, n'volve f Clier kd on ''s sig f men team idenc	ce conference on November revealed that Client #1's ed in her habilitation and in #1's ISP revealed the July 19, 2007. Further gnature attendance sheet inbers of the client's were present, however, e that the client's mother reeting.			1. See response to W 124.		1/3/08
	26, 2007 at 4; 0 mother and sis te and care. Revie	PM, erare wof(e conference on November revealed that Client #2's involved in her habilitation Client #2's ISP revealed the August 11, 2007. Further			2. See response to W 124.		1/3/08

PRINTED: 12/12/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDI MARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIE. (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G171 11/29/2007 NAME OF PROVIDER OR SUP LIER STREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE CARECO 11 WASHINGTON, DC 20002 (X4) ID SUMMA LY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFI RENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROFICIATE COMPLETION TAG REGULATOF 'CIR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) W 209 Continued From page 17 W 209 review offthe SP's signature attendance sheet revealed seve at members of the client's interdisciplina y jeam were present, however, there was no widence that the client's family member were present at the meeting. W 212 483.440(c)(3) i) INDIVIDUAL PROGRAM PLAN W 212 The comprehingive functional assessment must See response to W 159 #2. identify the pri senting problems and disabilities and where po sible, their causes. This STANDARD is not met as evidenced by: Based on obs in ation, staff interview and record review, the facility failed to ensure that clients who was receiving psychotropic medications had a psychiatric as: essment for two of the two clients in the sample. (Clients #1 and #2) The findings is clude: Observatio i of the evening medication. administration on November 26, 2007, at 6:05 PM; revealed :: lient #1 received Buspar 15 mg and Seroquel 100 mg and Depakote 500 mg by mouth. Interview with the nursing staff on November 26, 2007, at approximately 6:20 PM, revealed that the medication was prescribed for behavior man: gement. Review of the client's current physic ans orders, on November 27, 2007 at approximately 10:00 AM, revealed that Buspar 15 mg and S∈ oquel 100 mg and Depakote 500 mg by mouth t vice a day was incorporated in a Behavior Supr or: Plan (BSP) dated February 2, 2007, to address behaviors associated with property destriction, disrobing, physical aggression, in: ppropriate touching, self-injurious

behaviors and enuresis.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDI ZURE & MEDICAID SERVICES

PRINTED; 12/12/2007 FORM APPROVED ()MB NO. 0938-0391

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					IULTIP LDING	LE CONSTRUCTION		(:(3) DATE SURVEY COMPLETED		
			09G171	B, WIN	1G		11/2	C 29/2007		
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W 212	Review of Cliapproximately psychotropic address beha Atypical Psycinurse on Nov 6:20 PM, reverseribed for the client's cu November 27 revealed that and Depakote was incorpora (BSP) dated Fehaviors ass disrobing phy touching, self-2. Observation PM, revealed Zyprexa 10 m Interview with 26, 2007, at a the medication management, physicians or capproximately also receives was incorpora to address bel and masturbai aggression, pr self-injurious k. Review of Clie July 13, 2007.	nt #10:00 or sisted the first state of the first st	I's medical evaluation dated 17, on November 27, 2007 at 0 AM, revealed that the cations were prescribed to associated with a diagnosis of Interview with the medication of 26, 2007, at approximately that the medication was avior management. Review of physicians orders, on 7 at approximately 10:00 AM, ar 15 mg, Seroquel 100 mg mg by mouth twice a day and a Behavior Support Plan ary 2, 2007, to address and with property destruction, aggression, inappropriate ous behaviors and enuresis. The evening medication lovember 26, 2007, at 6:05 the evening medication lovember 26, 2007, at 6:05 the evening medication hedication nurse on November simately 6:20 PM, revealed that a prescribed for behavior siew of the client's current on November 27, 2007 at 0 AM, revealed that the client exa 10 mg in the evening and a BSP dated March 30, 2007, rs associated with disrobing screaming/crying, physical by destruction, and	W	212					

DEPARTMENT OF HI ALTH AND HUMAN SERVICES
CENTERS FOR MEDI DARE & MEDICAID SERVICES

PRINTED: 12/12/2007 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IULTIA ILDING	IPLE CONSTRUCTION	(1:3) DATE SURVEY COMPLETED		
	1		09G171	B. WIN		· · · · · · · · · · · · · · · · · · ·		C 29/2007	
NAME OF P	1, 1				17	REET ADDRESS, CITY, STATE, ZIP CODE 701 24TH STREET, NE VASHINGTON, DC 20002		O/LOC!	
(X4) ID PREFIX TAG	(EACH DEF)	LIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOUL) BE	(X5) COMPLETION DATE	
W 212	Continued Fr	m pr	age 19	W 2	212				
	psychotropic address beha Schizoaffective review of the documented of assessment.	nedic ricrs a Dis lient vider	cations were prescribed to associated with a diagnosis of sorder (Bipolar type). Further s's medical record revealed no noe of a psychiatric						
W 227	483.44∪(¢)(4) 	INDI	VIDUAL PROGRAM PLAN	W 2	<u>277 </u>				
	objectives ned as identified to required by particular to the second sec	cessa i / the i ragra i RD ii	gram plan states the specific ary to meet the client's needs, comprehensive assessment aph (c)(3) of this section. is not met as evidenced by: with the observation, staff of review, the facility failed to	l		See response to W 159 #3.	· .	1/3/08	
	ensure that a address self n identified by th	i : cbje i edica r : inte r : siss r : anpli	ectives was developed to sation training program need as erdisciplinary team (IDT) in the sessment for one of the two le. (Client #1)				:		
	observed bein The Licensed client's medication as indicated that self-medication as indicated that	n aldn Pract Fra	2007 at 6:05 PM, Client #1 was ministered his medications. tical Nurse (LPN) prepared the s, poured a cup of water and t's medication in applesauce ed the water into the client's The nurse also took the c. Interview with the LPN lient does not participate in a gram. Review of the selfment dated August 8, 2007 lient would benefit from a call self medication program.						

		RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			.POR OMB N	M APPRO\ O. 0938-0:
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER;	(X2) MULTII A. BUILDING	PLE CONSTRUCTION	() 3) DATE	
		09G171	B. WING			С
NAME OF	PROVIDER OR SUP LI	ER			11/	/29/2007
CAREC	0 11		17	EET ADDRESS, CITY, STATE, ZIP CODI 01 24TH STREET, NE	<u> </u>	
(X4) ID	SUMMA Y	STATEMENT OF DEPICIENCIES		ASHINGTON, DC 20002	1 1	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AP DEFICIENCY)	L'ALLL DE	(X5) COMPLETI DATE
W 227	Continued From	page 20	W 227	DE TOLENOT)	1	
	Review of the In-	No. id / Day			1	
	Lagran Depteu Je	dividual Program Plan (IPP) 77, 2007 revealed no program			1 1	
	l ace of object le	JOI the client to receive training			; I	
	in sen illedica lo:	I A data sheet was in the I				1
	INFOICATION AC MI	Distration Record (MADa) bank				
	Lacueu nicidae 20	EDS in Which the client should				
		e medication administration.				
	The IPP failed to	identified program objective in		:		
		OGRAM IMPLEMENTATION	301010	•		
1	!! i	-	W 249			
	As soon as the in	terdisciplinary team has		See response to W 196 #1.		11
	romunated a citem	ITS IDDIVIDUAL DECORPORA MAA		•		1/3/68
í	Each Cheuf the 21's	BCBIVE & CODEDUCE CONTROL				17 = 7 = 4
ļ	interventions : act	n consisting of needed services in sufficient number				
	and neduction to a	SUDDOIT the achievement of the]		
Ι,	COLCUMES IDEL [[Lig	ed in the individual program		•		l I
	plan.	and program				!
	1.1					
-	This STANDA 2D	is not met as evidenced by:				
, -	Daged Official IAM	JIOO STOTI INTODIONA AND AND AND AND AND AND AND AND AND A	1	,		
, •	reinicanoti, (III Tale	IIIIV falled to provide	1.	,		
	-ammons ac. At I	reatment for one of the two		1		
'	clients in the sump	le. (Client #2)			I	
₹	The findings ir slud	le.				
	41	-				
1	Evening ob erv	ations conducted on November		1		
-	, Y, EUV 11 ILUM 11 ILUM	FIVE Uptil approximatals 6-40				
1.	'M revealed the fo 2:	llowing observations for Client		,	;	
	∦ (
a.	At 4:00 PM the	client was observed sitting in		1 1		
ne	er bedroom, : lone).		•	i	

CARECO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDI :/	RE	& MEDICAID SERVICES				OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) M		IPLE CONSTRUCTION	() 3)-DATE SI COMPLE		
			09G171	B. WII				C 9/2007	
NAME OF P	ROVIDER OR SUP L	lier			STE	REET ADDRESS, CITY, STATE, ZIP CODE			
CARECO	11				1	701 24TH STREET, NE VASHINGTON, DC 20002			
(X4) ID PREFIX TAĞ	(EACH DEFI :II	ENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF CROSS-REFERENCED TO THE APPROPRIES OF TH	ULI) BE	(X5) COMPLETION DATE	
W 249	screaming from sitting in her characteristing in her characteristing in her characteristics. At 5:00 PW on the wall. d. At 5:02 PW The direct care her pants up, in the client composed from the client composed from the staff was observed and water. The staff's legistine staff's leg	the interest of the staff. It is a clied. It is a clied the clied	client was overhead bedroom. The client was alone listening to music, client was banging her head client pulled her pants down, frequested that the client pull times. After multiple request direct care staff retrieved a and water. The direct care feeding the client potato chips and held onto the direct care time of feeding. After the nished the client grabbed both onty lifting him from the floor. Client banged her head on the client pulled her pants down dult protective undergarments	W	249				
	j. At 6:45 PM, below the wais		lient pulled her pants down						

k. At 6:52 PM the client was observed sitting on

DEPARTMENT OF HE ALTH AND HUMAN SERVICES PRINTED: 12/12/2007 CENTERS FOR MEDI ZARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIE: OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: () 3) DATE SURVEY A. BUILDING COMPLETED 09G171 B. WING 11/29/2007 NAME OF PROVIDER OR SUP LIER STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 11 1701 24TH STREET, NE WASHINGTON, DC 20002 SUMMA LY STATEMENT OF DEFICIENCIES (X4) ID 1D PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFLIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE REGULATOR ((IR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD) BE TAG CROSS-REFERENCED TO THE APPROFRIATE TAG DEFICIENCY) W 249 Continued Fir m page 22 W 249 the toilet with he door wide opened. I. At 7:15 PM the client was escorted back to her bedroom to complete evening personal hygiene. 2. Interview v ith the direct care staff indicated that the client likes to stay in her bedroom. Review of the Client #2's Behavior Support Plan (BSP) dated I arch 30, 2007 indicated proactive strategies to it clude: a. The client: hould be engaged in a task as often as possible to alleviate boredom. b. The client : hould be closely supervised to prevent disrot ng. c. The client should wear an additional one or two layers of c othing to prevent or delay clothes stripping. In the event that clothes stripping occurs, direct :are staff should cover the client with a towel pr or to escorting her to the bedroom or bathroom to redress. d. Staff shoul provide frequent verbal praise throughout the day, every day. There was no evidence that the direct staff implemented (lient #2's BSP as written. W 252 483.440(e)(1) FOGRAM DOCUMENTATION W 252 Data relative to accomplishment of the criteria See response to W 196 #1. specified in cli-nt individual program plan objectives must be documented in measurable terms.

FORM CMS-2567(02-99) Previous Virislans Obsolete

This STANDALD is not met as evidenced by:

Event ID: UKU111

Facility ID: 09G171

If continuation sheet Page 23 of 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/12/2007 CENTERS FOR MEDI JARE & MEDICAID SERVICES FORM APPROVED <u>OMB N</u>O. 0938-0391 STATEMENT OF DEFICIENCIE. (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION ()(3); DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING C B. WING 09G171 11/29/2007 NAME OF PROVIDER OR SUP "LIER STREET ADDRESS. CITY, STATE, ZIP CODE 1701 24TH STREET, NE CARECO 11 WASHINGTON, DC 20002 SUMMA LY STATEMENT OF DEFICIENCIES (EACH DEFI LIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION. PREFIX (EACH CORRECTIVE ACTION SHOUL) BE CROSS-REFERENCED TO THE APPROFRIATE (X5) PREFIX COMPLETION TAG REGULATOR (CIR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) W 252 Continued From page 24 W 252 the entire feering. After the potato chips were finished the c ent grabbed both of the staff's legs and slightly lifing him from the floor. f. At 5:08 PM, the client banged her head on the wall, four time s. g. At 5:12 PN, the client pulled her pants down and removed her soiled adult protective undergarmen s (APU). h. At 5:20 PN the client came into the living room and sat ha chair. At 6:20 PM, the medication nurse was attempting to sid the client her dinner while the client was sea ed in the living room chair. The client consum id two spoonfuls of food. The nurse mixed 1 4 leaspoon of the client's crushed medications in to her food. The client refused the food and med bation. Several minutes later the nurse was observed putting the remained medications in o a jelly sandwich. The client consumed the medication sandwich. j. At 6:30 PM, the client removed her top, exposing her coords bra. k. At 6:45 PM the client pulled her pants down below the wais : . . I. At 6:52 PM, the direct care staff took the client to the bathroor i. The client sat on the toilet with the door wide opened. m. At 7:15 PN the client was escorted back to her bedroom to complete evening personal hygiene,

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDI MERE & MEDICAID SERVICES

PRINTED: 12/12/2007 FORM APPROVED ()MB NO. 0938-0391

AND PLAN OF CORRECTIO		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(C3) DATE SURVEY COMPLETED
	09G171	B, WING	11/29/2007
NAME OF PROVIDER OR S	UP 'LIER	STREET ADDRESS, CITY, STATE, ZIP COI 1701 24TH STREET, NE WASHINGTON, DC 20002	
PRÉFIX (EACH D	MARY STATEMENT OF DEFICIENCIES EF. JENCY MUST BE PRECEDED BY FULL TOF / CIR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORFREEIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE ADEPTICIENCY)	SHOUL) BE COMPLETION
Review of (BSP) date 2007 at apprention of the Antecedent On Novem data chart in maladaptive data failed November the data has the BSP for functional at 483.440(f)(CHANGE) The individed least by the professional but not limit failing to predict of the sample of the sample. The finding The QMRP as performan progress.	Fin m page 25 Clir nt #2's Behavior Support Plan d I larch 20, 2007, on November 27, production of 2007 and revealed that or acord maladaptive behaviors on the the shavior Consequence (ABC) charts be 27, 2007 at 3:00 PM, review of the revealed that the client #1 had no e the aviors. Review of the behavior to effect the behavior observed on 26 2007. There was no evidence that at the client, which was necessary for a tess assment of the client's progress. 1)(ii) PROGRAM MONITORING & ual program plan must be reviewed at equal fied mental retardation at a direvised as necessary, including, ted to situations in which the client is ognass toward identified objectives hat the efforts have been made. DA (E) is not met as evidenced by: the riew and record review, the en at Retardation Professional led to ensure each clients Individual and IFP) was revised after the client take progress with the identified for one of the two clients included in (Client #1) sinclude: fai ac to revise Client #1's programs and a measures reflected a lack of the client's documentation and IPP yed on November 28, 2007 at 12:30		96.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/12/2007 CENTERS FOR MEDI SARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIE: (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (2.3) DATE SURVEY COMPLETED A. BUILDING B. WING C 09G171 11/29/2007 NAME OF PROVIDER OR SUP LIER STREET ADDRESS, CITY, STATE, ZIP CODE CARECO 11 1701 24TH STREET, NE WASHINGTON, DC 20002 SUMMA LY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFI HENCY MUST BE PRECEDED BY FULL REGULATOR 'CIR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION: PRÉFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROFRIATE TAG DATE DEFICIENCY) W 257 Continued From page 26 W 257 PM. 1. According a Client #1's IPP that was reviewed on November 28, 2007, 12:30 PM reflected the following obje :thres: a. The client ad an objective which stated "Given a written telephone number, [the client] will dial the number correctly with verbal prompts 90% of the tirr e during the trials conducted during the month for hree consecutive months". Review of the program data documentation revealed no documentation since March 2007. The IPP reflected that he client continued this objective in the 2007 Individual Support Plan (ISP). The objective was evritten from the previous ISP. The objective vas reimplemented without revisions b. The client r act an objective which stated "Given a patte n of coins and bills, [the client] will pick out the value of money to math the price of the items shown 60% of trials per month for three consecutive manths". Review of the program data documen ation revealed no documentation since June 22, 2007. The IPP reflected that the client continue I this objective in the 2007 ISP. The objective ras rewritten from the previous ISP. The obje tive was reimplemented without revisions. c. The client had an objective which stated "Given verbal | rcmpts, [the client] will prepare a simple meal w in 100% independence for three consecutive months". Review of the program data documentation revealed no documentation since June 2007. The IPP reflected that the client

continued this ibjective in the 2007 ISP. The objective was I swritten from the previous ISP.

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STATEMENT OF DEFICIENCIE. AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU(IPLE CONSTRUCTION	()(3) DATE SURVEY COMPLETED		
	1	!	09G171	B. WII	VG _		1 1	C 9/2007	
NAME OF PROVIDER OR SUP LIN			LNER		1	REET ADDRESS, CITY, STATE, ZIP CODE 701 24TH STREET, NE VASHINGTON, DC 20002	·	<u></u>	
(X4) ID PREFIX TAG	(EACH DEF	HENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE	
W 257	revisions. d. The client "When preser [the client] wil independently for three cons program data documentatio reflected that the 2007 ISP, the previous I reimplemente e. The client I client] will part for 30 minutes Review of the revealed no do The IPP reflective in the rewritten from	was indicated was ted was ted was ted was ted was ted to the color of the part of the	n objective which stated with arts and crafts of choice, on task for up to 30 minutes to 6 of the trials within a month over months. Review of the mentation revealed no ite june 2007. The IPP ient continued this objective in objective was rewritten from the objective was	W 2	257				
W 262	was evidence aforementions 483.440(f)(3)(in CHANGE) The committed monitor individually in the opinion client protections.	of do	ogram monitoring & uld review, approve, and rograms designed to manage vior and other programs that, committee, involve risks to	W 2	262	The Human Rights Committee is so meet on January ##fand will review restrictive measures for both people sample.	wthe use of	1/3/68	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDI MARE & MEDICAID SERVICES

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I STATEMEN	NT OF DEFICIENCIE		(VI) BEOMBERIA DE LA COLO				<u></u> <u></u>	<u>NB M</u>	<u>). 0938-039</u>
AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION	(E: 1)	DATE COMPI	
		09G171		B. WING			1 1		C
NAME OF	PROVIDER OR SUP	LIER		<u> </u>	STREET AD	DRESS, CITY, STATE, ZIP CODE	ــــ	11/	29/2007
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(X4) ID PREFIX TAG	(EACH DEF	SIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	× / _	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHORT CORRECTIVE ACTION SHORT COSS-REFERENCED TO THE APPROPRIED TO TH	HILLO F	i =	(X5) COMPLETION DATE
W 262				W 2	62			1	
	Based on obs review, the fa (HRC) failed t	enyati ility's revia suires	on, staff interview and record Human Rights Committee ew and approve the use of for two of the two clients in	, ,	02		, , ,		
W 263	the Qualified I (QMRP) reveathe HRC had techniques (i.e psychotropic r for Clients #1 483.440(f)(3)(CHANGE	28, 2 the Hillental led the provincial #2 PRC should from the provincial #2 provincial	007 at approximately 1:00 RC minutes and interview with Retardation Professional e there was no evidence that yed the use of restrictive avior support plan and ations) to manage behaviors [See W124] DGRAM MONITORING & ald insure that these programs with the written informed parents (if the client is a	W 20	_	ce response to W 124.			1/3/68
	review, the fac client's behavi- the use of beh conducted with the client, pare- guardian for tw (Clients #1 and The finding inc	rvatio lity fai r inter rvior n the w ts (if c of th #2) ucles:	not met as evidenced by: n, staff interview and record led to ensure that each vention technique, including nodification drugs was ritten informed consent of the client is a minor) or legal the two clients in the sample. btain informed consent prior we measures as described in						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDI :ARE & MEDICAID SERVICES

F'RINTED: 12/12/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION			(X2) I	NULT	IPLE CONSTRUCTION	() 3) DATE SURVEY			
,	o. Gordand lon		IDENTIFICATION NUMBER:	A. BU			"	COMP	LETED
_		1	09G171	B. WI	NG_				С
NAME OF I	PROVIDER OR SUP	LIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	ㅗ_	<u> 11/</u>	29/2007
CARECO	O 11	,			1	701 24TH STREET, NE VASHINGTON, DC 20002			
(X4) ID	SUMMA	Y STA	TEMENT OF DEFICIENCIES		<u> </u>			<u> </u>	·
PREFIX TAG	(EACH DEF)	HENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULDI	ŔE	(X5) COMPLETION DATE
W 26 3	Continued Fro	m pa	ge 29	١٨/ ٠	263		—-	+	<u> </u>
	Clients #1 and sedation. [Se	#2's • \'V1'	Behavior Support Plan and 24]		203				
W 331	483.460(c) NI	RSIN	IG SERVICES	w:	331				
	The facility muservices in ac	st pro	ovide clients with nursing nce with their needs.		ļ	·			
	,	1						ļ	
	This STANDA	RE) is	not met as evidenced by:					i I	
	Based on obs	∍rvatio	on, interview and record						
	services in ac	uity ta	alled to provide nursing ance with the needs of two of					1	
	the two clients	includ	ded in the sample. (Clients		-	-		}	
	#1, and #2)		The samples (One) to				1	}	
	The findings in	ebula	<u>.</u>						
	1. The facility	i nurs	e failed to schedule medical					i	
ł	consultation a	point	ments for Client #1, timely.			1. See response to W 195. The new R Supervisor will hold scheduled grand least monthly with the P.		s at	1
	a. Review of (lient :	#2's medical record on			least monthly with the Primary Care P and the QMRP to ensure people's med	hys ci Real n	ian	
	November 28,	2007	at approximately 12:30 PM			are addressed completely and timely.	ea n	EEUS	1.1.01
1	consultation or	A.pril	ent had a gynecology 26, 2007. The				1	!	113/08
	recommendati	on from	m the consultation indicated		ŀ	•	ļ	,	
Ì	a normal vağırı	ai exa	mination and to follow-up in				,		
!	two years if the	pap s	Smear is normal. However	•					
	record.	esions	of the pap smear in the						
	b. Review of	Client	#2's medical record on				ı		
	November 28,	2007 (at approximately 12:30 PM						
1 '	evesied that t	e cile.	nt hád a mammogram on						-
	UNSUCCESSIN	77. () Dieni	ne examination was ew with the Registered				•	1 1	
1 1	vurse on Nov€	mber :	29, 2007 at 2·20 PM						
	ndicated the s.	ie Wol	Ild speak with the Primary				1		
1	∍are Physiciar	€ We	ek later to request a breast						
	sonogram. At	h∈⊩tim	e of the survey, there was						
RM CMS-2561	(02-99) Previous Ve	sic ns Ot	Solete Event In 1921 1444						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING			D. 0938-0391 SURVEY LETED
<u> </u>		09G171	B. WING			11/	C 29/2007
CAREC	,	!	ş	TREET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE WASHINGTON, DC 20002			2012001
(X4) ID PREFIX YAG	(EACH DEFI	LY STATEMENT OF DEFICIENCIES SIENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRICE (PROSS-REFERENCE)	ULD E	iΕ	(X5)' COMPLETION DATE
W 331			W 33	1			•
W 336	2. The facility treatment ser health. [See 3. The facility authorized perstorage area. 483.460(c)(3) Nursing service certified as not review of their quarterly or modient need.	failed to ensure that only sons have access to the drug	W 33	2. See response to #1 above. The RD we schedule another dental appointment and that staff take the required records. Dent recommendations will be completed one informed consent is acquired. 3. The Director of Disability Services will provide training to the QMRP, RD and sauthorized access to the drug storage are look combination to the drug storage are	ddns all c vr ii taifo a Ti	itten	1/3/68 1/3/08
	Based on inte failed to ensure by the nursing frequent basis sample. (Clie The finding inc.) Review of Clie November 27 revealed that	view and record review, the facility that a health status was reviewed staff on a quarterly or more for one of the two clients in the 1t #1)		The new RN Supervisor will complete the quarterly assessment.	le:		13/08
W 356	the medical re assessment h with the Regis quarterly asse 483.460(g)(2); TREATMENT	cold revealed that the first quarter d not been completed. Interview and Nurse confirmed that the sment had not been completed. CIMPREHENSIVE DENTAL it ensure comprehensive dental	W 356	See response to W 331 #1 and #2.	-		1/3/08

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CENTERS FOR MEDI 24RE & MEDICAID SERVICES

PRINTED: 12/12/2007 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		- ;	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		IULTIPI	LE CONSTRUCTION	(7:3) DATE SURY COMPLETE		ETED
	11 1	09G171		B. WING					C 29/2007
NAME OF F	PROVIDER OR SUF	LIER		•	170	ET ADDRESS, CITY, STATE, ZIP CODE 01 24TH STREET, NE ASHINGTON, DC 20002	_		
(X4) ID PREFIX TAG	(EACH DEF	RENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDI	ΒĖΕ	(X5) COMPLETION DATE
W 356	treatment ser needed for re restoration of health. This STANDA Based on inte failed to ensu services for th	rices reith, RD is view e pone a mai	that include dental care pain and infections, and maintenance of dental so not met as evidenced by: and record review, the facility aprehensive treatment of dental health for		356				
W 383	The finding in On November with many mistonsultation of that the client teeth removed appointment of dental surgeo the medical be could not asso the time of the scheduled. The received the re December 6, 483.460(l)(2) I RECORDKEE Only authorize keys to the drivents This STANDA Based on obse facility failed to	ludes 28, 2 sing t sted [1 needs The chedu I hi ok, th ss the surve ere w com 006 RUG PING 1 pers g stor ersu	007, Client #2 was observed eeth. Review of the dental December 6, 2006 revealed to have additional seven e client had a dental eled on March 20, 2007 with a electric care staff did not take erefore, the dental surgeon e client laboratory values. At ey, there was no appointment was no evidence that the client mended dental care since e STORAGE AND	W 3	383	See response to W 331 #3.			1/3/08

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

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STATEMEN AND PLAN (IT OF DEFICIENCIE OF CORRECTION	;	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION	$\overline{}$	/	SURVEY
			09G171	₿. WII	NG_			11/:	C 29/2007
NAME OF F	PROVIDER OR SUP	LIER		· -		REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		E3/200 /
			<u> </u>			WASHINGTON, DC 20002			
(X4) ID PREFIX TAG	(EACH DEF	HENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	JD PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDE	ĖΕ	(X5) COMPLETION DATE
W 383	1	٦,	· •	w	383				
	PM, a reques Record (MAR He indicated inurse's statio was observed and retrieve ti Qualified Mer (QMRP) on N direct care stanumbers from personnel red approximately the direct care medication en 483.470(i)(1) i The facility ma quarterly for e This STANDA Based on staf facility failed to all shifts. The finding indicated Interview with Professional (incompattern on Nove	25, 20 of the solution was a least to the solution with the MAC of the solution was also the solution with the solution was also the solution was also the solution with the solution was also the solution was also the solution with the solution was also the solution was also the solution with the solution was also the solution was also the solution was also the solution with the solution was also the solution was	2007 at approximately 4:15 be Medication Administration is made to the direct care staff. he MARs were locked in the 4:30 PM, the direct care staff hlock the nurse's station door ARs. Interview with the etardation Professional ber 29, 2007 revealed that the etardation DMRP. Review of the on November 28, 2007 at PM revealed no evidence that or the QMRP were trained etardation drills at least hift of personnel. It is not met as evidenced by: view and record review, the evacuation drills quarterly on it is: ualified Mental Retardation D) and review of the staffing etar 29, 2007 at approximately the scheduled shifts are as	W 4		The new RD and the QMRP will ensure drills are completed and documented in accordance with the schedule and regula	'		1/3/68

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDI DARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION			DATÉ SURVEY	
1		DENTI TOATION RUMBER,	A. BUILDING			COMPLETED	
	<u> </u>	09G171	B, WING_			144	.C 29/2007
NAME OF F	. 1			REET ADDRESS, CITY, STATE, ZIP CODE 1701 24TH STREET, NE WASHINGTON, DC 20002	L _		23/2001
(X4) ID PREFIX TAG	(EACH DEF	RY STATEMENT OF DEFICIENCIES DIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD	ĖE	(X5) COMPLETION DATE
	3rd Shift 11 F Weekends 1st 7 AM to 7 2nd 7 PM to Further interv staff was requested and communi This STAND/ The facility's scontrol techni The finding in On November observed pulliher soiled add (APU's), while APU on the firobserved pick gloves on.	PIM AM evv with the QMRP revealed that the ired to conduct a drill once per 1 shift. Review of the fire drill log that the facility failed to hold fire lls since their move into the facility There was no evidence that fire ducted quarterly on all shifts. Ni=ECTION CONTROL an active program for the ntrol, and investigation of infection able diseases. RID is not met as evidenced by: aff failed to implement infection lues. ludes: 26, 2007 at 5:12 PM, Client #2 was 19; her pants down and tearing off t protective undergarments in her bedroom. The client put the or. The direct care staff was 19; up the soiledAPU's, with no	W 440		lg on		1/3/08
	The facility mu	SINING AREAS AND SERVICE st provide table service for all and will eat at a table, including lonairs.	W 483				·
RM CMS-256	7(02-99) Previous \	resistan Obaquata					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDI	ARE	& MEDICAID SERVICES				<u>C'M</u>	B NO.	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(> 3)	DATE SURVEY COMPLETED	
	09G171		B. WING) 9/2007	
NAME OF P	ROVIDER OR SUP	LIER			17	REET ADDRESS, CITY, STATE, ZIP CODE 701 24TH STREET, NE VASHINGTON, DC 20002			
(X4) ID PREFIX TAG	(EACH DÉFI	HENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULI) B		(X5) COMPLETION DATE
W 483	Continued Fr	Fri m page 34		W 4	83			- -	
	Based on obstacility failed t	∌n/at ⊬p/ro	is not met as evidenced by: ion and staff interview, the vide enough table room for five ing in the facility.			The QMRP will ensure that people who will eat the table have adequate comfort space to do so.		and	1\$ 108
	The finding in	:lude	s:						
	alone. The th bedroom with The direct car client potato c onto the direc feeding. After	e clired a load a state riple a care the postn	ent remained in the bedroom ect care staff entered the g of potato chips and water. If was observed feeding the and water. The client held e staff's leg during the entire botato chips were finished the of the staff's legs and slightly floor.						·
	to fed the clien seated in the liconsumed two mixed 1/4 teamedications in food and medication nuremained medication medication and medication m	t her ving spoor to he catio ser w catio	edication nurse was attempting of dinner while the client was room chair. The client confuls of food. The nurse of the client's crushed or food. The client refused the on. Several minutes later, the was observed putting the ons into a jelly sandwich. The e medication sandwich.						·
	1								
	· · · ·	•							

PRINTED: 12/12/2007 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		O9G171		A. BUILDING B. WING	E CONSTRUCTION	(X:) DATE SURVEY COMPLETED C 11/29/2007
NAME OF PI	ROVIDER OR SUPF	JER:	1701 24TH	RESS, CITY, ST STREET, NE TON, DC 200	102 	
(X4) ID PREFIX TAG	AMAGU DECI	Y STATEMENT OF DEFICIENCY IENCY MUST BE PRECEDED BY CR LSC IDENTIFYING INFORM	Y FULL	IĎ PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE DATE
	November 26 The survey we process. A reselected from various degree. The findings observations and staff, and incident reportered that with the Contreatment. 3502.2(c) Mis Modified diet (c) Reviewed. This Statute Based on recensure that comodified diet quarterly by The findings. Review of R. November 2 the resident assessed/ret three month.	rivey was conducted from 2007 through November is initiated using the full straight inclom sample of two resists a population of four femises of disabilities. If the survey were based at the home, interviews were the review of records, in its. The outcome of the straight failed to be in a fittion of Participation in A straight in the facility failed to be in a fittion of Participation in A straight in the facility failed to be in a fittion of Participation in A straight in the facility failed to show a straight in the facility failed to show each of the three residents in the facility failed to show each of the failed to show each of	survey idents were ales with on with clients acluding survey compliance active AREAS ietitian. by: alled to s with east ords on vidence that least every terly nutrition	1043	The client's diet will be revegistered dictition.	DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 2001 JAN -4 P 12: 27 Injewed by the

LABORATORY DIRECTOR'S O ! PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Driectn 9,

9 Alisabele & Sentes 1/3/0

PRINTED: 12/12/2007 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		DENTIFICATION NUMBER.		A BUILDING B. WING		(X2) DATE SUF COMPLET C 11/29	ED
NAME OF PI	ROVIDER OR SUPF		1701 24TH	RESS, CITY, ST STREET, NI TON, DG 200	TATE, ZIP CODE E 902		
(X4) ID PREFIX TAG	CONTRACTOR DEED	Y STATEMENT OF DEFICIENCI IEHCY MUST BE PRECEDED BY OR LSC IDENTIFYING INFORM	1 PULL 1	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULE BE IE APPROPRIATE	(X5) COMPLETE DATE
I 058	Continued From 3502.16 MEA A review and nutritionist she ensure that exprescribed a nutrition according to the findings of the resident's assessed/rethree months.	m page 1 SERVICE / DINING AF consultation by a dietitian ill be conducted at least ch resident who has bee nedified diet receives ad ding to his or her Individ- ar. s not met as evidenced and review, the facility fa- the of the three residents had been reviewed at li- the consulting dietitian. notude: sident #1's medical received micropied diet had been tieved by the dietitian at sident #1 had been doc-	REAS n or quarterly to en dequate lual by: iled to with east	1 058			
1 06	Each bathro equipped widispenser, sadequate light This Statute Based on old properly equipped to the same and	m that is used by resident toilet tissue, a paper to ap for hand washing, a sting. is not met as evidenced servation, the GHMRP for peach bathroom with the erns to meet each residence to the servation.	ents shall be owel and cup mirror and d by; failed to ne		The Residential Director (RI soap and paper towels are al bathroom. The RD will ensurable in the bathroom.	ways availt ble in the	1/3/02
	The finding	roludes:				<u> </u>	

AND PLAN OF CORRECTION IDENTIFICATION 09G171		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	MBER:	A, BUILDIN		C 11/29/2007	
NAME OF PE	ROVIDER OR SUPP	IE/t	1701 24TH	I STREET, I	STATE, ZIP CODE NE		
CARECO	11		WASHING	TON, DC 2	0002	FOTION	(X5)
(X4) ID PREFIX TAG	(EAOU DEEK	(STATEMENT OF DEFICIENCE ENCY MUST BE PRECEDED BY OR LSC IDENTIFYING INFORM	T FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETE
1 082	Continued Fro	n page 2		082			
'	AM, no soap t mirror were av	29, 2007, at approximate or hand washing, paper the ailable in the first bathroidents and staff usage upon the staff upon t	om in the				-
1 095	3504.6 HOUS Each poison a locked cabi of each reside	nd caustic agent shall be et and shall be out of di	e stored in rect reach	1 095	The RD will ensure that caustic ag stored in the food preparation area		1/3/08
	Observation a	s not met as evidenced of not interview revealed the tolerance that caustic according preparation and ser	at the agents were			;	
ļ	The finding in	cludes:					
	November 29	vironmental inspection of a 2007 at approximately a were observed stored the in a cabinet underne	11:00 AM, in a food				
1 09	6 3504.7 HOU	EKEEPING		1 096			
	No poisonou in a food pre	i or hazardous agent sho paration, storage or serv	all be stored ing area.	i	See response above.	ı	1/3/08
	Observation GHMRP fails	is not met as evidenced and interview revealed to d to ensure that caustic the food preparation and	hat the agents wer	e	·	-	
	The finding	i ıc.udes:			·		
L	L tice Administra			. 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SU COMPLE	red		
			09G171		B. WING_		1 1	/2007
NAME OF P	ROVIDER OR SUPP	IEľ?	0.00.77	STREET ADD	RESS, CITY, S	TATE, ZIP CODE	,	
CARECO				1701 24TH WASHING	ISTREET, N TON, DC 20	<u> </u>		
(X4) ID PŘEFIX TAĞ	/EACH DEFIC	ENC:	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO GROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
1 096	Continued Fro	n pa	age 3	·	1 096		1	ļ
	November 29, caustic agents	200 wer	mental inspection on 7 at approximately 1° re observed stored in 1 a cabinet underneat	1:00 AM, a food	•			
1 135	3505.5 FIRE	AFE	≣ΤΥ		I 135			
	order to test t	e ef	shall conduct simulated fire drills in e effectiveness of the plan at least a year for each shift.			The move to the facility took place in The QMRP and RD will ensure that it take place as scheduled quarterly on a that the drills are properly documents	ire d ills all shifts, and	1 2
	Based on inte	viev to e	t met as evidenced b w and record review t ensure that each shift rill four times a year.	he			i	i /3/68
1	The finding in	alud	es:				! . !	
	Professional pattern on No	Vem QIVI	Qualified Mental Ret RP) and review of the iber 29, 2007 at appro d the scheduled shift	e staffing oximately				
	Weekdays 1st Shift 7 AN 2nd Shift 3 P 3rd Shift 11 F	a !' 1	11 PM					
	Weekends						j. 	
	1st 7 AM to 7 2nd 7 PM to							
	the staff was month on ea	requ h si	with the QMRP revea lired to conduct a dril hift. Review of the fire	l once per				
Health Reg	julation Administrat	วท			6803	11/21/444	If continue	allon sheet 4 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP	LE CONSTRUCTION	(X I) DATE SURVEY COMPLETED C		
			09G171		B. WING	<u></u> .	· ·	9/2007	
NAME OF PE	ROVIDER OR SUPF	JER	000111	STREET ADD	RESS. CITY, S	TATE, ZIP CODE	:		
CARECO				1701 24TH WASHING	STREET, N TON, DC 20				
(X4) ID PREFIX TAG	(FACH DEFI	LENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)	SHOUL[BE	(X5) COMPLETE DATE	
i 135	evacuation dr	that Is si	age 4 the facility failed to h ince their move into the was no evidence th	ne facility	I 135				
	drills were con	duc	ted quarterly on all sh	iifts.	l 167				
[167	The manual s	ıa i	ES AND PROCEDUR incorporate policies a least the following:		1 107	•			
	qualifications,	staf	ich covers job descrip f/resident ratios, train , health inventory;	otions and ing and			1		
	Based on rev Mentally Reta ensure that the included a pol- descriptions a	: : : : : : : : : : : : : : : : : : :	of met as evidenced by frecords the Group of Persons (GHMRP) to Policies and Procedure address personnel, qualifications, staff/red staff development, a	Home for failed to es' Manual job sident			!		
' ·	The finding in	: dud	les:				;		
	November 28 a policy that a descriptions	20 ddr nd (icies and procedures 07, failed to provide e essed personnel, job qualifications, staff/re d staff development,	evidence of sident					
I 203	Each superv	i iors Vitla	NEL POLICIES shall discuss the cont each employee at the at least annually ther	e beginning	1 203	The job descriptions will be revistaff annually. Those who were timely will be completed.		1/3/68	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 09G171		A BUILDING		I 1			
NAME OF P	ROVIDER OR SUPF	JER			RESS, CITY, S I STREET, N	STATE, ZIP CODE	; ;		
CARECO	11				TON, DC 20002				
(X4) ID PREFIX TAG	(FACH DEFIC	I Y STATEMENT OF DEFICIENCIES I IEI/ICY MUST BE PRECEDED BY FULL I OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI GROSS-REFERENCED TO THE APP DEFICIENCY)	OULE BE	(XS) COMPLETE DATE	
1203	This Statute i Based on rec provide evider the contents of employee at t and annually: The finding in Review of the 2007 failed to care staff (#8)	rio and i cert job ie.bi nere lude pers prov #9,	t met as evidenced b review, the GHMRP f that the supervisor dis descriptions with ea eginning of their emp	ailed to scussed ch loyment mber 29, e direct	I 203				
I 206	Each employing annually there certification the performed and would allow high duties.	e, p afte at a i tha m o	NEL POLICIES prior to employment a pr., shall provide a phy health inventory has at the employee 's he prior to perform the r pot met as evidenced to	rsician ' s been ealth status required	I 206	The Human Resources Director will staff and consultants have current he certificates signed by a physician on	alth	1/3/08	
	Based on interfacility failed regulations pondered as a comparison of the finding in the State regulation of personnel which time the care staff (Stone medicati	rvie rtai ecti cluc ulat edo are iff #	ws and record review chieve compliance with ning to health (22 DC ton 3509.6).	v, the th State CMR d a review , 2007, at t six direct and #14), liatrist,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPI		DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING DRESS. CITY, STATE, ZIP CODE		(X.) DATE SURVEY COMPLETED C 11/29/2007		
CARECO		1701 241		1701 24TH	STREET, N	E		
(X4) ID PREFIX TAG	(EACH DEFI	IENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	'FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULL BE	(X5) COMPLETE DATE
I 206	Continued Fro	-	_		l 206		 	
l 224	(a) Overview not limited to, retardation, a frequently usr of individuals living skills; This Statute Based on obsreview, the G	oring following the solution of the delifit solution of the so	pram shall include, but wing: ental retardation include, inition, causes of meriated health implication edications, the history mental retardation, and the met as evidenced batton, staff interview at the each staff.	uding, but htal ons, and y of care and daily by: http://www.nd.com/	1224 -	The QMRP will provide training to st Overview of Mental Retardation.	affi in an	1)3)68
1 225	2007, revealed training in over 3610.5(b) ST Each training limited to, the (b) Human do (birth to death This Statute Based on reconstruction of the training statute and the training statute and the training statute and statute and training statute and training statute and	d iha rviev AFF prog folio velo ond r velt	gram shall include, but owing: opment through the lit of met as evidenced I review, the GHMRP that raining was provide to	to provide on. ut not be fe cycle by: failed to	I 225	The QMRP will provide training to s Human Development.	staff on	1/3/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDING	LE CONSTRUCTION	(X:) DATE SUI COMPLET C : 11/29	ED
NAME OF PI	ROVIDER OR SUPF		1701 24TH	RESS, CITY, S I STREET, N TON, DC 20			
(X4) ID PREFIX TAG	(EACH DEFI	Y STATEMENT OF DEFICIENCIE IEINCY MUST BE PRECEDED BY OR LSC IDENTIFYING INFORM	' FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULT BE	(X5) COMPLETE DATÉ
1 225	2007 revealed	mipage 7 training records on Nove that the GHMRP failed to an Development.	mber 29, o provide	I 225			
l 227	Each training, limited to, the	FF TRAINING pringram shall include, but following: pritrol for staff and reside to the met as evidenced but included in the met as evidenced in the met as evidenced but included in the met as evidenced in the met a	nts;	I 227	The RN Supervisor will provide train on infection control.	jing 17 staff	1/5/08
I 228	Each training limited to, the (e) Resident This Statute Based on rec	s lights; s not met as evidenced b ord review, the GHMRP f	by: ailed to	I 228	The QMRP will provide training to Resident's Rights.	stafi oa	1/3/08
l 229	ensure effect staff. The finding in Review of the 2007 reveale training in Re	/eitraining was provide to clildes: training records on Nove I that the GHMRP failed sicient's Rights. FF TRAINING program shall include, but	each ember 29, to provide	I 229	The QMRP will provide training to resident's needs in behavior suppor technology and sexuality.	staff on each ts, as astive	,/3/08

_____CARECO

		- -	T		-		(X i) DATE S	SUÉVEY
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION		(X1) PROVIDER/SUPPLIED IDENTIFICATION NUMBER 1	R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING B. WING		C 11/29/2007	
NAME OF RE	OVIDER OR SUPF	_ _IER	09G171	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
CARECO				1701 24TH WASHING	STREET, N TON, DC 20	IE 0002 		
(X4) ID PREFIX TAG	/EACH DEEL	TE: NO	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULTIBE	(X5) COMPLETE DATE
1 229	residents to be to, behavior in recreation, to technologies; This Statute Based on revigence GHMRP faile staff training in Review of the 2007, the GH	eass see and al co surver train train MIRI age	related to the GHMR rved including, but no agement, sexuality, nu primunications, and a set met as evidenced by training documents provide evidence to vidicated by residents'	t limited trition, issistive y: , the alidate need. mber 9, ning on	I 229			
1 230	Imited to, the (g) Habilitation This Statute Based on obtreview, the factor in the factor in the factor in the facility for demonstration in the facility for demonstration in the facility factor in the facto	proficility services and services are services and servic	gram shall include, buowing: anning and implement of met as evidenced to ation, interview and re y failed to ensure that rovided with initial and bled the employee to pectively, efficiently, and	tation; py: ecord each continuing perform his d vas capable ents #1 and ir Individual		The QMRP will ensure that staff ar clients' individual Support Plans ar Habilitation.	e trained on ad As tive	1/3/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		-	(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM	R/CLIA //BER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X:) DATE SURVEY COMPLETED C 11/29/2007		ED
NAME OF PI	ROVIDER OR SUPF	JER		1701 24TH	RESS, CITY, S STREET, N TON, DC 20	TATE, ZIP CODE E 002			
(X4) ID PREFIX TAG	SUMMAI (EACH DEFK	IEIIC'	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	Š FŲLL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULC BI	E ATE	(X5) COMPLETE DATE
l 232	Continued From 3510.5(i) STA Each training limited to, the	F T	RAINING	not be	1 232 1 232	The QMRP will ensure that the staff a on health and hygiene.	retai	u ed	1/3/08
l 291	This Statute Based on recensure effecti staff. The finding in Review of the 2007 revealer	I hyç rc rc rc re trair that hea	t met as evidenced by eview, the GHMRP fa aining was provide to es: ning records on Nove to the GHMRP failed to alth and hygiene.	y: alled to each mber 29,	l 291	a Sylami deficiency V	711.		
	signed by ear This Statute Based on rec ensure each signed by the The finding in	h ind sino rdi esid indiv	be kept current, date dividual who makes a sevidenced by the GHMRP falents records were dayidual completing the est	n entry. y: iled to ited and protocol.		See response to federal deficiency W	(11° -		; /3/ठ४
1420	Each GHMR training to its and maintain	' s ha re sid th os	TION AND TRAINING all provide habilitation dents to enable them se life skills needed to rith the demands of the	and to acquire cope	1 420	See response to federal deficiency V	V22 /.		1/3/68

		(X1)	PROVIDER/SUPPLIEF	1001 IA			zven i	ATE SURVE	
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G171		IBER:	A, BUILDING B. WING	LE CONSTRUCTION		OMPLETED C 11/29/200			
			090171	STREET ADD	L CITY ST	TATE, ZIP CODE	<u> </u>		
NAME OF P	ROVIDER OR SUPF.	IER							
CARECO	11		WASHING		I STREET, NE TON, DC 20002			· ·	
(X4) ID PREFIX TAG	(EACH DEFIC	EIICY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY, DENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULC B	<u> </u>	(X5) MPLETE DATE
I 420		and to ac	chieve their optim		I 420				
	This Statute i Based on obs review, the Gl and training w would enable skills needed demands of their optimum social functior the sample. (The finding in	not met in ation, MRP fail as provid nem to a prope meil evels of nu for or Resident	I social functioning t as evidenced by staff interview an led to ensure hab led to its resident acquire and maint more effectively w conments and to a physical, mental ne of the two resi #1) y Report - Citation	d record bilitation s that ain life ith the chieve and dents in					
1 422	Each GHMRF and assistanc the resident ' This Statute Based on inte GHMRP failer assistance was accordance w	shall proside to reside the consument of	I AND TRAINING ovide habilitation, dents in accordant all Habilitation Plates as evidenced by directory review, the habilitation, trained to residents in Individual Habilitation, the sample.	training ce with an. /: he sining and		See response to federal deficiency W	196	1)	3)08
1 429	See Federal I	eficiency TATION	y Report Citation N AND TRAINING r shall arrange fol	6	[429	See response to federal deficiency W			/3/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION		ATE SUF OMPLET C 11/29/	EÒ
NAME OF P	ROVIDER OR SUPF	JER	•	1701 24TH	RESS, CITY, S' I STREET, N TON, DC 20				
(X4) ID PREFIX TAG	(EACH DEFI	JENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL ION)	ID PREFIX TAĞ	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULT BE IE APPROP KIA	E TE	(X5) COMPLETE DATE
1 429	Continued From resident to be Individual Hat appropriately This Statute Based on state GHMRP failer resident had Individual Halleast annually included in the The finding in See Federal Individual Halleast annually included in the The finding in See Federal Individual Halleast annually included in the The finding in See Federal Individual Halleast annually included in the The finding in See Federal Individual Halleast annually included in the The Habilitatic GHMRP shall be limited to. (f) Health carruse and self-aid, care and devices, previous, the General Individual Halleast In	m relative control of the state	valuated and to receive tion Plan, which is updatest annually. In the tast evidenced by: erview and record revie provide evidence that en reevaluated and receive tion Plan that was updated in the two resident mple. (Resident #1) Ites: Ciency Report - Citation TATION AND TRAINING and training of residents lude, when appropriate, following areas: Including skills related to inistration of medication of prosthetic and orthowe health care, and safe of the tast evidenced by: ation, interview and receive and received the salining of residents in the salining of	an ted w, the ach ived an ated at is W259 G by the but not nutrition, in, first tic ety);	1429				1/3/08
	The finding in	sluc		S					

	OF DEFICIENCIES		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA MBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X:) DATE SURVEY COMPLETED C	
		_ •	09G171		B, WING _		I I	9/2007
NAME OF P	ROVIDER OR SUPF	.IER	-			STATE. ZIP CODE		
ÇARECO	11			1701 24TH WASHING	ISTREET, I TON, DC 2	NE: 0002		
(X4) ID PREFIX TAG	(EACH DEFIC	EHC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULT BE	(X5) COMPLETE DATE
1 437	Continued Fro	n,page 12			1437			
1 437	3521.7(g) HAI	ILITATION AND TRAINING			l 437		·	
	GHMRP shall	nand training of residents by the nature, when appropriate, but not re-following areas:				See response to federal deficiency W	196	1/3/08
	development : telephone, let utilization of c books, newsp	nd c eriwi mm iper: suc	i (including language isage, signing, use o riting, and availability unications media, su s, magazines, radio, i ch specialized equipn	f the and ch as television,				
	Based on obs review, the fa- and training fo	ental ility i r two	met as evidenced by tion, staff interview ar failed to provide habit o of the two residents esidents #1 and #2)	nd record litation				
	The finding in	lude	95:					
	See Federal (efici	ency Report - Citatio	ns W196			-	
1500	3523.1 RESIL	ENT	'\$ RIGHTS		l 500	0.1152-32	W124 :	
	that the rights protected in a	of ire	dence director shall e esidents are observed dance with D.C. Law applicable District ar	d and 2-137, this		See responses to federal deficiencies W130, W137, W140, W159, W195, W209, W212, W227, W252, W257, W263.	W 195, i	1/3/08
	Based on obs	∌r/a IMR	t met as evidenced by tion, interview and re P failed to ensure the n clients rights.	cord				
	The finding in	alu'de	es:		-			

		10ENTIFICATION NUMBER:		A BUILDING B. WING DDRESS, CITY, S	(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING DRESS, CITY, STATE, ZIP CODE H STREET, NE STON, DC 20002		TE SURVEY MPLETED C 11/29/2007
(X4) ID PREFIX TAG	(EACH DEF)	Y ISTATEMENT OF DI IEHCY MUST BE PR OR LSC IDENTIFY!!	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULT BE E APPROP RIATI	(X5) COMPLETE DATE
J 500	Continued Fro	— , ———— n, pagė 13		1 500			
	W130, W137,	W'140, W159, V	t - Citations W124, V195, W196, V257, W262 and				
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		;;					
	·	1					
:		14 1					
Health Regu	lation Administrati	n :					

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COM	(2 3) DATE SURVEY COMPLETED C 11/29/2007	
NAME OF D	ROVIDER OR SUP	1 ((2)2)	1 1	STREET ADD	RESS, CITY, S	STATE, ZIP CODE			
CARECO	i.	LIEK		1701 24TH	STREET, N TON, DC 20	NE			
(X4) ID PREFIX TAG	(EACH DEF	JENC	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	FROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPLICATION OF THE APPLICATIO	ひしょう 身足	(X5) COMPLETE DATE	
R 000	INITIAL COM	MEN	TS		R 000				
	November 26 The survey w process. A r	200 as ini ndor a po	was conducted from 7 through November tiated using the full so nearly sample of two residuation of four femaldisabilities.	urvey lents were					
1	observations and staff, and incident repo revealed that	at the the i ts. T the f	survey were based of home, interviews will be evident of records, income of the subscillity failed to be in comparticipation in Act	th clients luding irvey ompliance					
R 125	The criminal criminal histo contract worl in all jurisdict employee or	packe y of er fo oris v	ground check shall di the prospective empl the previous seven within which the prosp act worker has worke seven (7) years prior	sclose the oyee or (7) years, pective	R 125	The Director of Human Resources will that all direct care staff have criminal lachecks completed and in their files.		1/3/08	
	Based on the failed to ensu disclosed the employee or seven (7) ye the prospect	revie re crim contr rs, ir re er ided	t met as evidenced bew of records, the Gliminal background chinal history of any proact worker for the presult all jurisdictions within ployee or contract within the seven (7)	IMRP necks espective evious n which vorker has					
	Review of th 2007 reveale	peredicted	sonnel files on Noven GHMRP failed to pro						
_	ulation Administra		 - - - -			TITLE		(XB) DATÉ	
		PROV	IDER/SUPPLIER REPRESE	NTATIVE'S SIG	NATURE				
STATE FOR	₹M ;		<u> </u>		6430	UKU111	If co	otinuation sheet 1 of :	

STATEMENT OF DEFICIENCIE 3 AND PLAN OF CORRECTION NAME OF PROVIDER OR SUF 3L ER CARECO 11			1701 24Ti		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING DRESS, CITY, STATE, ZIP CODE 4 STREET, NE			C 11/29/2007	
(X4) ID SUMM. RYSTA PREFIX (EACH DEF CIENC		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF COMPRETIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE		HOUI D	BE I	(X5) COMPLETE DATE	
R 125	Continued F	orn p		· _ [R 125	DEFICIENCY)			
	direct care s	af (S	taff #4, #9, #13 and #	#14).					
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Hoofth D	ulation Administr	-Figure	· · · · · · · · · · · · · · · · · · ·			·			